Benefits Open Enrollment FAQs

1. **When is the CY2022 Benefits Open Enrollment (BOE) period?**
   BOE begins October 18, 2021. All changes must be entered in your HR Self-Service account on the HR Gateway by 11:59 p.m. on November 9, 2021. BOE includes Flexible Spending Account (FSA) Open Enrollment and insurance benefits enrollment. It is now a single, annual enrollment period held in the fall each year.

   Instructions for accessing your HR Self-Service account can be found at the Online Help link, on the HR Gateway page, under the Get Help section. If you have questions, do not have Internet access, or need assistance, please contact the MI HR Service Center at 877-766-6447, Monday through Friday, 8:00 a.m. to 5:00 p.m.

2. **What is the effective date of coverage?**
   The effective date of coverage for BOE changes and enrollments is January 1, 2022. This aligns all State sponsored plans under a calendar-based plan year. The coverage period is January 1, 2022 through December 31, 2022.

3. **I enrolled in a different plan this year. When will I get my new insurance cards?**
   Insurance cards will be mailed to individuals at the end of December, prior to the start of coverage. If you require additional copies, contact the insurance provider at the number on the back of the card.

4. **When is required supporting documentation due?**
   When adding a new or previously removed individual, you must submit eligibility documentation to the MI HR Service Center* by November 12, 2021 for the corresponding enrollments to be valid.

   *Auditor General and Judicial must submit the required documentation to their HR office by November 12, 2021.

5. **What is Other Eligible Adult Individual (OEAI) Coverage?**
   NEREs (non-exclusively represented employees) and the bargaining units AFSCME, MCO, MSEA, UAW, and SEIU Local 517M negotiated this benefit, which allows employees who do not have a spouse eligible to enroll in the State of Michigan health plans to enroll one OEAI if the individual meets all of the eligibility criteria. Dependent children of an OEAI may also enroll in health insurance only, under the same conditions that apply to dependent children of employees, if dependent eligibility criteria are met. Please see OEAI Eligibility Criteria and Required Documentation for additional information.

   Employees who wish to enroll an OEAI can do so online during the annual BOE period, either through HR Self-Service, or, by contacting the MI HR Service Center directly. Additionally, all required documentation must be submitted to the MI HR Service Center by November 12, 2021 to maintain enrollment.

   In accordance with IRS regulations, State of Michigan employees are responsible for paying taxes associated with the fair-market value of enrolling an OEAI and the OEAI's dependents. Additional information on OEAI tax implications is available on the Employee Benefits Division website.

Benefits Open Enrollment FAQs

6. **Can I add an OEAI after the open enrollment period?**
   No, you may only add an OEAI and their dependents during the open enrollment period each year (or within 31 days of your initial hire). If the criteria for enrollment of an OEAI or the OEAI's dependent child(ren) are no longer met, the employee must notify the MI HR Service Center within 14 calendar days. Coverage will end effective the date that the eligibility criteria are no longer met.

7. **What if my coverage needs change after the Benefits Open Enrollment (BOE) period?**
   After BOE ends, changes in coverage will only be allowed for a qualifying life event (QLE). The coverage change must be consistent with the QLE and each event requires documentation. Some examples of a QLE are:
   - You move outside of your HMO's service area:
     - You may enroll in a health insurance plan authorized for your area. The effective date will be the first day of the pay period after your move.
   - You get married or divorced:
     - You may enroll a new spouse within 31 days of your marriage. The effective date of the insurance is the first day of the next pay period after the MI HR Service Center receives notification.
     - In the event of a divorce you must remove a spouse and step-child(ren) from insurance immediately. The effective date of the removal will be the date of the divorce.
     - Or, you may newly enroll in health coverage if you lose insurance coverage as a result of a divorce.
   - Your spouse dies and you are covered under that spouse's insurance plans:
     - You may newly enroll in the State group insurance plans.
   - An eligible child is born, adopted, or you gain guardianship of a-child:
     - You may add a new dependent to your insurance coverage within 31 days of acquiring that dependent through birth, adoption, or legal guardianship. The effective date will be the date of birth, adoption or legal guardianship.
   - Your spouse begins or ends employment:
     - You and your eligible dependents may enroll in State group insurance coverages if your insurance coverage is lost as a result of a change in your spouse's employment.
     - Or, you may cancel your State group insurance (or opt out) if you enroll in your spouse's plans.
   - Your spouse changes from part-time to full-time (or vice versa), or takes an unpaid leave of absence resulting in a significant change in your coverages:
     - You and your eligible dependents may enroll in State group insurance coverages if coverage is lost or significantly reduced as a result of a change in your spouse's employment status.
     - Or, you may cancel your State group insurance (or opt out) if you enroll in your spouse's plans.
   - There is a significant change in your coverages (or your spouse's coverages) through your spouse's employer plan:
     - You and your eligible dependents may enroll in State group insurance coverages if coverages through your spouse's employer plan are lost, canceled, or significantly changed.
     - Or, you may cancel your State group insurance (or opt out) if you enroll in your spouse's plan.

   Notify the MI HR Service Center of a QLE as soon as possible, but no later than 31 days following the QLE occurring. **Do not wait until you have the official documentation to contact MI HR Service Center**. You will be required to provide proof of dependent eligibility. Details about required documentation is available by visiting www.mi.gov/docs4ebd.

8. **Can I waive all health care or dental options completely? That is, forego enrolling in any health coverage?**

Benefits Open Enrollment FAQs

Yes, however it is your employer's intent to ensure that you have at least a basic level of health insurance coverages, be sure that you are enrolled elsewhere (through a spouse or dependent) before waiving all health care.

During the enrollment process, select "Health Waive with Rebate" and/or "Dental Waive with Rebate". If you are not enrolled in another State of Michigan health or dental plan, you will receive a $50 biweekly rebate under the health option, and a $100 lump-sum rebate in January 2022 under the dental option. The $50 biweekly rebate for health insurance waiver will not be paid if you are not in pay status.

9. **Can I receive the $50 biweekly rebate if my spouse is also a State of Michigan employee or retiree?**
   No, two premiums are not payable for the same person. Therefore, state-employed couples can carry their insurance coverages separately (each as employees) or as one family enrollment with dependent/spouse coverage. And neither are eligible for the $50 biweekly rebate upon waiving coverage. Please refer to the Employee Eligibility Guidelines page for more information.

10. **If I am married to another eligible State employee, can I enroll as both an employee and a dependent under two of the same categories of coverage? For example, the State Health Plan PPO and the Catastrophic Plan?**
    No. Existing eligibility rules do not allow you to carry two enrollments in the same category of State group coverages. Each eligible person (employee, spouse, child, OEAI, or OEAI dependent) can enroll only once. Two premiums or rebates are not payable for the same person.

    You and your spouse can enroll separately (both as employees), OR, as a family unit (with one of you enrolling as a dependent). If you enroll separately, either one of you can cover your children, but you may not enroll the same child(ren).

    State-employed married or divorced employees may cover any eligible child(ren) in either parent's plan, as long as each child is only covered once. In the event employees cannot agree which parent will cover the child(ren), the parent who has covered the child(ren) first during their employment with the State of Michigan will cover the dependent child(ren).
    Employees should be aware that one life insurance claim will be paid in the event of a dependent's death, even if both parents paid premiums for a child's life insurance policy.

11. **If I'm enrolled in an HMO or PPO, how do I get emergency care when I'm outside of the plan's service area?**
    All of the State of Michigan group health plans cover immediate emergency care anywhere in the world. However, there may be certain requirements before benefits are processed, such as reporting the emergency within a reasonable time period. Contact your Insurance Carrier for more details.

    What if I wish to change "primary care physicians" or what if my physician does not renew his or her contract with the HMO?

    Contracted providers have the option of not renewing their contracts by providing advance notice to the HMO. Generally, contracts are not renewed because a physician is retiring, relocating outside of the HMO's service area, or changing the nature of his or her practice (e.g., from primary care to specialty care). Because HMOs allow members to select another primary care physician from among those who are available to care for new patients, State employee members will not be allowed to disenroll from an HMO outside of an open enrollment period due to a need to select another available primary care physician.

12. **What coverages are available if I am laid-off, or on a leave of absence, or if one of my family members is no longer eligible to be covered as a dependent?**

Benefits Open Enrollment FAQs

Employee Benefits Division (EBD) policy, collective bargaining agreements, and/or federal COBRA law provide options for continuing enrollments in any State group health, dental, vision, and life insurance plans. In addition, conversion policies are available from the health and life insurance plan administrators. Details about continuation of coverage through the EBD are available on the COBRA page. Details about conversion policies are available from the insurance plan administrators.

13. **If there are no generic alternative medication available, will I still be charged the copay that applies for the brand-name medication?**
    Yes. If a prescription is filled with a brand-name medication, whether or not a generic alternative medication is available, the brand-name copay will be charged both through retail and mail order.

14. **How am I charged if I request a brand-name medication when a generic alternative is available?**
    Dispense As Written (DAW) penalty applies to the cost of your medication if you or your physician request the brand name when a generic alternative is available. The DAW penalty is the cost of the copay plus the difference in cost between the brand name and generic alternative medication.

15. **What are the differences between a copay, a deductible, and an out-of-pocket maximum?**
    Copays are a fixed amount you pay for a covered service at the time you receive that service. The amount may vary by the service provided. An example would be an office visit copay at your primary care physician's office.

    A deductible is the amount you pay for expenses before the insurance plan will cover the remaining costs, outside of copays. Some services may be covered at a certain percentage "after deductible," which means you will pay for the cost of that service until you have reached your deductible amount for the plan year.

    An out-of-pocket maximum (OOPM) is the maximum dollar amount you would be required to pay for covered medical services during the plan year. Once this maximum amount is reached, you will no longer pay any out-of-pocket costs for co-insurance, deductibles for covered services, copays, or prescription copays. You would still be responsible for the pay-period cost of your insurance benefit.

16. **What happens if I move to an address outside of my current HMO's coverage area?** You are not able to remain enrolled in your current HMO if your new residential address is outside of its provider-specific coverage area, even if you lived within the coverage area when you originally enrolled. However, a move placing your residential address outside of your coverage area constitutes a life event, giving you 31 days from your change of address to selecta new plan for which you are eligible. If, after 31 days, you do not enroll in a new health insurance plan, you will be automatically enrolled in the State Health Plan PPO (BCBSM)and your next opportunity to change your insurance election will be Benefits Open Enrollment or an eligible qualifying life event, whichever occurs first. Visit the ZIP Code Tool to verify the plans you are eligible for.

17. **Who can I call for assistance if I still have questions?**
    For assistance, call the MI HR Service Center at 877-766-6447, Monday through Friday, 8:00 a.m. to 5:00 p.m.